IV. Instructions for the Completion of the Support Plan

General Instructions

The *Support Plan* will be used for people who receive SCDDSN sponsored Level I Service Coordination Services. **The Support Plan format may not be expanded, reduced or changed.**

For those receiving Level I Service Coordination, a *Support Plan* must be completed:

- By the 45th calendar day following the determination of eligibility for SCDDSN services
- Within 365 calendar days of the last *Support Plan*
- By the 45th day of being transferred from Level II Service Coordination
- By the 45th day of being transferred from Early Intervention
- Before MR/RD Waiver or HASCI Waiver Services are authorized/provided.

The Service Coordinator is responsible for completing the *Support Plan* and must do so based on the information gleaned from the most recent *SCDDSN Service Coordination Annual Assessment* and with input from the person and/or his/her legal guardian. Each person/legal guardian must be offered the opportunity to meet with the Service Coordinator face-to-face for the purpose of completing the *Support Plan.* If desired, the person/legal guardian may request that others of his/her choosing be invited to this meeting. Meetings should be held at times and locations that are reasonable and convenient for all parties. Choice of a face-to-face Plan meeting and, if applicable, meeting participants , date and time of the meeting, and reasonable location for the meeting will be documented in the service notes. Regardless of the meeting, the Plan must be completed by the established timeframes. A completed, signed, and dated Plan must be developed and implemented every 365 days prior to expiration of the current Plan. No services can be authorized or provided in the absence of a current plan. Services provided in the absence of a current, valid Plan cannot be reimbursed by Medicaid.

Instructions

Include identifying information as indicated by the form. The date the *Support Plan* is completed by the Service Coordinator is the "Plan Date", and should be recorded on the **"Plan Date"** line on page 1 of the *Support Plan*. If a meeting is held, the "Plan Date" will be the date the meeting is held as indicated in Section E "Meeting Attendees" of the documents. Implementation is expected as soon as the plan is completed, which is the date on the "Plan Date" line.

The Service Coordinator who authors the Plan must sign the plan. This is required and is based on a State Plan Medicaid requirement. It is **not** required that the plan be signed by an assigned Service Coordinator who did not author the plan.

A. Service Coordination

People in the following circumstances need ongoing and/or more intensive Service Coordination (Level I):

- Those awaiting DDSN eligibility;
- Those on the DDSN critical waiting list;
- Those receiving MR/RD or HASCI Waiver services;
- Those residing in a DDSN supported residential placement other than an ICF/MR or residing in alternative residential placement;
- Those served concurrently by DJJ (unless otherwise approved by DDSN);
- Those residing in a nursing home (unless otherwise approved by DDSN);
- Those residing in a community residential care facility/boarding home (unless otherwise approved by DDSN);
- Those categorized as "At Risk" or "Time-Limited Eligibility" (unless otherwise approved by DDSN);
- Those with medical (including genetic) conditions requiring consistent, coordinated care by general or specialty physicians, therapists, and other allied health professionals who demonstrate a need for monitoring;
- Those with health risk indicators (such as high blood pressure or unmanaged diabetes); or those who have expressed health or safety concerns that neither they nor others have been able to resolve, appear not to have recognized, are not addressing, or are refusing to address;
- Those engaging in behaviors with serious health, safety, or legal consequences;
- Those whose behaviors threaten the health and safety of others;
- Those whose current living situation is in jeopardy or will likely be in jeopardy;
- Those whose financial resources/support or that of their family are in jeopardy.

Indicate the person's service coordination status by checking the appropriate response. A statement is included that describes the reason Service Coordination services are warranted. Throughout the year, these services, when needed, must be provided by the Service Coordinator. If not needed, a change in status may be considered. Unless otherwise indicated, at a minimum, the monitoring requirements outlined in the Service Coordination Standards and MR/RD or HASCI Waiver Manual must be met.

The need for monitoring in excess of the minimum requirements must be considered at least annually and, if additional monitoring is needed, the need must be included in this section of the Plan. Additional monitoring may mean:

1. an increase in the frequency of the monitoring (e.g. monitoring more frequently than quarterly for some or all services/supports),
2. an increase in the intensity of monitoring (e.g., face-to-face monitoring at regular intervals rather than monitoring by any other means)
3. or a combination of increased frequency and intensity.

When considering the need for additional monitoring, consider if circumstances such as, but not limited to, the following exist:

- The person does not effectively communicate problems or concerns to others. (Does the person make needs known verbally or through sign language? Can the person indicate such things as how he or she got a bruise or how his/her money was spent?)
- The person is physically dependent on others for basic care. (Does he/she have any capacity to physically protect him/herself?)
- The person engages in behaviors that are mentally and physically challenging for caregivers. (e.g., hitting, spitting, kicking, etc.; name calling, taunting, cursing, etc.; extreme uncooperativeness; etc.)
- The person does not have regular contact with family or friends who are not paid agency employees. (If family and friends are available, do they assist the person in decision-making or advocate on his/her behalf and in his/her best interest?)

These circumstances may indicate an increased vulnerability and, therefore, may indicate a need for increased monitoring. If increased monitoring is needed, indicate why it is needed and how the monitoring will be increased.

B. Compliance Officer Information

Enter the name and phone number of the Service Coordination Agency's Compliance Officer as required by SCDDSN policy 700-02-DD.

C. Emergency Planning

Describe the "back-up" plan and plan for natural disasters. It is <u>not</u> acceptable to assume that parents/family/responsible parties have planned for the person. The plan, for those living in their own homes, should be written specifically enough for someone outside of the home to implement if needed and reflect an understanding of what is needed. For those in residential services, it is acceptable to indicate that the provider has a specific plan.

D. Needs and Services

a. Need: Indicate what the person needs. This information should come from the *Assessment Summary and Planning Document.*

   If known, indicate if the need is related to one of the person's personal goals and, if so, indicate how it relates. For example, if a person desires to work in a retail store one day, then prevocational services may have goals and objectives that relate to duties in a retail store.

b. Service /Intervention to Address Need: Indicate the specific service /intervention that will be authorized/implemented in response to the need. If the service is funded by either the MR/RD or HASCI Waiver, appropriate Waiver service names must be used.

c. Date the Service /Intervention Included in This Plan: Note the date the Service /Intervention was included in this Plan. If the service was authorized/implemented during the previous plan year, the "Plan Date" from

page 1 of this document should be entered. If the Service /Intervention is being included for the first time during planning, enter the "Plan Date". If the Service /Intervention is being added to an existing Plan, enter the date it is being added.

d. Funding Source: Indicate the funding source for the Service /Intervention. Examples: SCDDSN funding, HASCI Waiver, MR/RD Waiver, Medicaid State Plan, Private Insurance, Family Support Funds, etc.

e. Amount/Frequency/Duration: The amount should reflect how much service someone will receive. For all services, a "unit" is specified. For Day Habilitation, Prevocational service, Facility-Based Rehabilitation Support, Residential Habilitation (except SLPI), and daily Respite a unit typically equals 1 day of service. For Supported Employment, SLP I Residential Habilitation, PCA, hourly Respite, etc. a unit equals 1 hour of service. For Assistive Technology, the number of units (how much of the service) and the dollar amount will be identified. Refer to the MR/RD or HASCI Waiver manual to determine specific Waiver service units. For Family Support, a dollar amount may be entered rather than a unit. Indicate how often (frequency) the person will receive the service and how long it will last (duration). For example "weekly" would be considered a frequency and "for 3 months" would be considered duration. If the service is on-going, meaning that the service will likely continue indefinitely, enter the next annual plan review date or 365 days from Plan date.

f. Provider Type: Indicate the kind/type of provider who will provide the service; NOT the actual name of the provider. Provider type relates to the service. Some examples are, but not limited to, the following:

    1. Respite services can be provided by a foster home, group home, SCDDSN Licensed Respite Caregivers, in SCDDSN Licensed Respite Facilities/Settings, in an ICF/MR, nursing facility, or by a respite provider chosen by the person/family.
    2. Personal Care services or Attendant Care services are provided by Personal Care providers or Attendant Care Providers.
    3. Specialized supplies, medical equipment and assistive technology are provided by a durable medical equipment provider.
    4. Individual Rehabilitation Support Services are provided by SCDDSN enrolled Rehabilitation Support Providers.

    For Home and Community Based Waiver participants, refer to the MR/RD Waiver Manual or HASCI Waiver Manual as appropriate for more examples.

g. Service Coordinator's Responsibilities / Person/Guardian's Responsibilities and Timeframe/Projected Completion Date: Indicate each person's

responsibilities related to arranging for, participating in the implementation of, and/or communicating about the service and its effectiveness in meeting the need. The intention is to assure that everyone's role is clearly understood and documented along with the timeframe or date by which the responsibility will be completed/ done. For example, the Service Coordinator will be responsible for providing information about the available providers by a specific date while the person will be responsible for selecting a provider and communicating their choice by a specific date.

For those enrolled in the MR/RD or HASCI Waiver, it is required that each participant's plan include all services regardless of the funding source. In particular, State Plan Medicaid services must be included in the Plan prior to their use. In order to assure that services are included, those services that will likely be accessed during the coming year should be included in the Plan. The following exemplifies how this can be done:

<table>
<tr><td colspan="2"># <u>1</u> . What does this person need? Routine and emergency medical care and services.

Does this need relate to a personal goal expressed by this person?
☒ Yes ☐ No ☐ Unknown
If known explain how? (Person's name) wants to be healthy as possible.</td></tr>
<tr><td colspan="2">Service / Intervention to address the need:
Physician visits, ER visits, Home Health Services, Durable Medical Equipment, Medical Transportation, Emergency Dental(include only if an adult), Pharmacy(include this only if previously not included; more specifically i.e., those with no routine medications would likely receive Rx for acute illness), Therapy (include only for children under age 21)
Note: Only in this context may multiple services/interventions be included in one section.</td></tr>
<tr><td>Date Service / Intervention was included in this Plan: Date of Plan</td><td>Funding Source for the Service / Intervention: State Plan Medicaid</td></tr>
<tr><td colspan="2">Amount, Frequency and Duration of Service/Intervention:
As needed and/or ordered by physician or specialist.</td></tr>
<tr><td colspan="2">Service/Intervention Provider Type: Medicaid enrolled providers</td></tr>
<tr><td colspan="2">Service Coordinator's Responsibilities related to Service/Intervention and Timeframes/ Expected Completion Dates: Offer choice of physician or health service provider (if not chosen already), monitor service use, and assist with accessing services if needed (for 12 months).</td></tr>
<tr><td colspan="2">Person/Legal Guardian's Responsibilities related to Service/Intervention and Timeframes/ Expected Completion Dates: Choose health care providers, access services, as needed or ordered, contact Service Coordinator for assistance if needed (for 12 months).</td></tr>
</table>

Need/Service/Intervention Change: This section will not be completed at the time of annual planning. Instead, it will be used to document changes to the plan.

i. Indicate the status of the Need - Has it been met or not?
ii. Indicate the kind of change being made to the Service/Intervention. Is it being revised or discontinued?
iii. -If the need was "not met" and the Service/Intervention is being "revised", explain what changes are being made to facilitate meeting the need. Some examples may be, but are not limited to, that "a change of provider type is requested" or the "times for the provision of the service need to be changed".

-If the need was "not met" and the Service/Intervention is being discontinued, explain why (the concern is that an important need still exists without being addressed). Examples of an explanation include, but aren't limited to, "The person no longer wishes to have this need addressed", "There has been a significant life change and this is no longer a priority".

-If a new need is identified during the course of the plan year, the Service Coordinator will document the need and any discussion surrounding the identification of the need in the service notes. The Service Coordinator will also add/complete a new "needs box" (complete sections as defined – "What does this person need… Service Intervention…Person/legal guardian responsibility, etc.) in Section E of the *Support Plan*. The "Date Service/Intervention was included in this Plan" should be noted as the date the new need was identified (not the date of completion of the Support Plan) and should correspond to service notes that document discussions related to the need.

E. Plan Attendees

This page will be signed by all who attend the plan meeting if a meeting is held. Indicate the date of the meeting and the name of the person for whom services/supports are being planned. During the meeting, all attendees must sign. If no face-to-face meeting is held, this section (page) will not be used.

For MR/RD or HASCI Waiver participants, when State Plan Medicaid services that will likely be accessed during the coming year are included in the Plan in the manner noted in the instructions, those services must be monitored. The following exemplifies how those State Plan Medicaid services may be monitored:

Monitoring and Review

(For use by Service Coordinators, not intended for distribution as part of the Plan unless specifically requested)

Service/ Intervention for Need #__1__

Routine and emergency medical care and services.

Has the service/intervention been provided/implemented?

☐ **Yes** *(Score yes only if one of the listed State Plan services was accessed during the quarter)*

A. If **yes**, did the service / intervention address the need? ☐ Yes ☐ No
If it didn't address the need, why not? ☐ The need changed.
☐ The service was not suitable/ appropriate.
☐ Other: _____

B. If **yes**, was the person/legal guardian satisfied with the service? ☐ Yes ☐ No
If not, why not and what actions have been/will be taken? _____

_____

C. If **yes**, was the person/legal guardian satisfied with the provider? ☐ Yes ☐ No
If not, why not and what actions have been/will be taken? _____

_____

☒ **No** *(Score no if none of the listed State Medicaid plan services were accessed)*

A. If **no,** what prevented the service from being provided? _____

Not needed during the quarter

Is this still occurring? ☒ Yes ☐ No
If so, what actions have been/ will be taken to address the reason it wasn't provided?

Not applicable (N/A)

Comments:

Person (put person's name) continues to need routine medical care and medical care in the event of an emergency.

Information sources used for review: *Person receiving services(put their name) and family(list family member or members' name)*

(Service Coordinator's Signature) *(Date Monitoring Completed)*

_____ _____

Completed by **Date**